

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G239 3-2-59 et

1813

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> c. LENGTH OF STAY IN Ib <b>Years</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>At home - 506 Washington Street</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>13 Cambridge</b> d. STREET ADDRESS <b>506 Washington ST.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William F. Applegarth</b>		4. DATE OF DEATH Month <b>Feb</b> Day <b>23</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 2, 1880</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>23</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Grocery Ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retail</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>George Applegarth</b>		14. MOTHER'S MAIDEN NAME <b>Hester Wright</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs William Applegarth</b>		Address <b>Cambridge Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Heart Disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>6 hours.</b> <b>4 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <b>19</b> Day <b>19</b> Year <b>19</b> Hour <b>a. m.</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10/14/58</b> , 19 <b>58</b> , to <b>2/23</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>2/23</b> , 19 <b>59</b> , and that death occurred at <b>12:30</b> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>136 Race St.</b> DATE SIGNED <b>2/23/59</b> ACTUAL SIGNATURE <b>Lawrence Maryanov</b> M.D. PHYSICIAN'S NAME (Type) <b>Lawrence Maryanov Cambridge, Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb 25, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Speddens Swards</b>		22d. LOCATION (City, town, or county) (State) <b>R F D # 3 Cambridge Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>LeCompte Funeral Service</b>		24a. REC'D BY REGISTRAR <b>FEB 26 '59</b>	
ADDRESS <b>Cambridge Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kinn</b>	

CERTIFICATE OF DEATH

1113

Blank form with horizontal lines for text entry.

RECEIVED  
MAY 10 1913  
U.S. DEPT. OF HEALTH  
BUREAU OF VITAL STATISTICS  
WASHINGTON, D.C.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1826 Item 9, Film G 239 3/3/59 gg

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RFD # 1, Cambridge</b>		c. LENGTH OF STAY IN 1b <b>5 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Home</b>		e. STREET ADDRESS <b>RFD # 1, Cambridge</b>	
3. NAME OF DECEASED (Type or print) First <b>Arthur</b> Middle <b>B oivin</b> Last		4. DATE OF DEATH Month <b>2</b> Day <b>12</b> Year <b>1959</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 27, 1892</b>
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dining car steward</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Rail Road</b>	
11. BIRTHPLACE (State or foreign country) <b>Ottawa, Canada</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Not known</b>		14. MOTHER'S MAIDEN NAME <b>Not known</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Hilda H. Boivin, RFD # 1, Cambridge, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Mace Jr.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED <b>2/12/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/15/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetary</b>		22d. LOCATION (City, town, or county) (State) <b>Parkville, Balto Co Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Le Compte Funeral Serv ice, Cambridge, Md.</b>		24a. REC'D BY REGISTRAR <b>FEB 17 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

1886

STATE DEPARTMENT OF HEALTH—Baltimore  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for name, age, sex, occupation, and cause of death. The form is oriented horizontally but contains vertical text labels for various fields.

NAME OF DECEASED: \_\_\_\_\_

AGE: \_\_\_\_\_

SEX: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

RESIDENCE: \_\_\_\_\_

DATE OF DEATH: \_\_\_\_\_

PLACE OF DEATH: \_\_\_\_\_

CAUSE OF DEATH: \_\_\_\_\_

DETAILS OF DISEASE: \_\_\_\_\_

SIGNATURE OF EXAMINER: \_\_\_\_\_

DATE OF EXAMINATION: \_\_\_\_\_

OFFICE OF THE MEDICAL EXAMINER: \_\_\_\_\_

1814  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> c. LENGTH OF STAY IN 1b <b>3 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cambridge Maryland Hosp.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bishops Head</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Brazilla G Bramble</b>				4. DATE OF DEATH Month Day Year <b>Feb 17 19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb 16, 1877</b>	
9. AGE (In years last birthday) <b>82 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Seafood</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>George Bramble</b>				14. MOTHER'S MAIDEN NAME <b>Mary Madre</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215 20 4971</b>		17. INFORMANT Address <b>Mrs B G Bramble Bishops Head Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive CVD</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arterio Sclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>?</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2-15</b> , 19 <b>59</b> , to <b>2-17</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>2-17</b> , 19 <b>59</b> , and that death occurred at <b>9:30</b> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cambridge</b> DATE SIGNED <b>2-18-59</b>							
ACTUAL SIGNATURE <b>S. B. Bramble</b> M.D. <b>Cambridge</b>				PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb 19, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Men. Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>LeCompte Funeral Service</b> ADDRESS <b>Cambridge Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 24 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

1821

1827

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>	c. LENGTH OF STAY IN 1b <u>From 1/7/29</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u> <u>23 x 2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hospital</u>		d. STREET ADDRESS <u>—</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Calvin</u> First <u>ALFRED</u> Middle <u>Coffin</u> Last		4. DATE OF DEATH Month <u>February</u> Day <u>7</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/13/98</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR: Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u> IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Thomas Coffin</u>		14. MOTHER'S MAIDEN NAME <u>Cora Trader</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT <u>Eastern Shore State Hospital</u> Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>4520</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> DUE TO (c) <u>Dementia Praecox, Catatonic</u>			INTERVAL BETWEEN ONSET AND DEATH <u>One wk.</u> <u>several years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>November 1950</u> , to <u>February</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2/7</u> , 19 <u>59</u> , and that death occurred at <u>12:20 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Simon Virkutis</u>		ADDRESS (Street, city or town, state) <u>Eastern Shore State Hosp</u> DATE SIGNED <u>2/7/59</u>	
PHYSICIAN'S NAME (Type) <u>Simon Virkutis</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/9/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>	22d. LOCATION (City, town, or county) (State) <u>BERLIN</u> <u>MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burbay</u>		ADDRESS <u>Berlin Md</u>	
24a. REGISTERED BY REGISTRAR DATE <u>FEB 10 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1828

## CERTIFICATE OF DEATH

Reg. Dist. No.

01822

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rhodesdale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rhodesdale</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Phillip - Corkran</u>		4. DATE OF DEATH <u>2/27</u> 19 <u>59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/21/1909</u>
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel C. Corkran</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Knight</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Mr. David D. Corkran Rhodesdale</u>	
17. INFORMANT <u>Mr. David D. Corkran Rhodesdale</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Cardiac Decompensation</u> DUE TO (c) <u>Coronary Artery Sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>4 yrs</u> <u>8 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/5</u> , 19 <u>42</u> to <u>2/27</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2/17</u> , 19 <u>59</u> , and that death occurred at <u>9:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dr. H. B. Plummer</u> M.D.		ADDRESS (Street, city or town, state) <u>Preston Md</u> DATE SIGNED <u>3/2/59</u>	
PHYSICIAN'S NAME (Type) <u>Dr. H. B. Plummer</u>		<u>Preston Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>3/2/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>East New Market</u>	22d. LOCATION (City, town, or county) (State) <u>East New Market Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Kilgough</u>		ADDRESS <u>E. N. Market St.</u>	
24a. REC'D BY REGISTRAR <u>MAR 6 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur D. Plummer</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH	
JAMES EARL RAY		M		39		W		12-1-38		MEMPHIS, TENN.	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN	
4-4-68		11:00 AM		HOME		HEART DISEASE		NATURAL		[Signature]	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESS		15. SIGNATURE OF DECEASED		16. SIGNATURE OF NEXT OF KIN		17. SIGNATURE OF CLERK		18. SIGNATURE OF JUDGE	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

TO BE FILLED BY PHYSICIAN OR OTHER PERSON QUALIFIED TO FURNISH SUCH INFORMATION. TO BE FILLED BY PHYSICIAN OR OTHER PERSON QUALIFIED TO FURNISH SUCH INFORMATION. TO BE FILLED BY PHYSICIAN OR OTHER PERSON QUALIFIED TO FURNISH SUCH INFORMATION.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1815

CERTIFICATE OF DEATH

01823

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Md. Hospital</u>				d. STREET ADDRESS <u>133 Pine St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Milbourne Cornish</u>				4. DATE OF DEATH Month <u>2</u> Day <u>11</u> Year <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 15 1876</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u>82</u> Days <u>82</u> Hours <u>82</u> Min. <u>82</u>		IF UNDER 24 HRS. Months <u>82</u> Days <u>82</u> Hours <u>82</u> Min. <u>82</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Dorchester</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>John Cornish</u>				14. MOTHER'S MAIDEN NAME <u>Isabelle Laws</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>220-09-826</u>		17. INFORMANT <u>Ernest Cornish, Cambridge Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>August</u> , 1958, to <u>February 11</u> , 1959, that I last saw the deceased alive on <u>February 10</u> , 1959, and that death occurred at _____ M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>227 Pine St-Cambridge, Md.</u>				DATE SIGNED <u>-2-12-59</u>			
ACTUAL SIGNATURE <u>J. Edwin Fassett</u>				M.D. <u>227 Pine St-Cambridge, Md.</u>			
PHYSICIAN'S NAME (Type) <u>J. Edwin Fassett, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-14-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>		22d. LOCATION (City, town, or county) <u>CAMBRIDGE</u> (State) <u>MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leon W. Hany</u> ADDRESS <u>CAMBRIDGE</u>				24. REC'D BY REGISTRAR <u>FEB 25 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hays</u>	

21 *nl*

## CERTIFICATE OF DEATH

Reg. Dist. No.

01824

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Worcester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Cambridge</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke City</b>	
c. LENGTH OF STAY IN 1b <b>8 months</b>		d. STREET ADDRESS <b>Oak Street</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eastern Shore State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ISAAC</b> Middle <b>JAMES</b> Last <b>COVINGTON</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>18</b> Year <b>1959</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/26/71</b>
9. AGE (In years last birthday) <b>87</b> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>printer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Newspaper</b>	11. BIRTHPLACE (State or foreign country) <b>Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>William Covington</b>	
14. MOTHER'S MAIDEN NAME <b>Anna Disharoon</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO. <b>216-12-1694</b>		17. INFORMANT <b>Eastern Shore State Hospital records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senile Psychosis</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ <b>19</b>	20d. INJURY OCCURRED While _____ Not while _____ of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <b>June 27</b> , 19 <b>58</b> , to <b>Feb 18</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Feb 17</b> , 19 <b>59</b> , and that death occurred at <b>8:35 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>E.S.S. Hospital, Cambridge, Md.</b> DATE SIGNED <b>2/18/59</b>			
ACTUAL SIGNATURE <b>Thomas J. Dredge</b>		M.D. <b>E.S.S. Hospital, Cambridge, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Thomas J. Dredge</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-20-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Crisfield Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Crisfield, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry L. Watson</b>		24a. REC'D BY REGISTRAR <b>FEB 24 '59</b>	
ADDRESS <b>Pocomoke City, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







1830

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WORCHESTER.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> COUNTY <b>CHESTERTOWN.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge.</b>		c. LENGTH OF STAY IN 1b <b>From 3/30/58.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eastern Shore St. Hospital.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>LOUISE</b> Last <b>WILL.</b>		4. DATE OF DEATH Month <b>February</b> Day <b>20</b> Year <b>1959.</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>2/6/86.</b>
9. AGE (In years last birthday) <b>73 yrs.</b>		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>14</b> Hours <b>37</b> Min. <b>2</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN CONNELLY.</b>		14. MOTHER'S MAIDEN NAME <b>DAVIS.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Eastern Shore State Hospital.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA.</b> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis.</b> DUE TO (c) <b>several yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>3 days.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/30</b> , 19 <b>58</b> to <b>Feb. 20</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Feb. 20</b> , 19 <b>59</b> , and that death occurred at <b>6:30 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>EASTERN SHORE STATE HOSPITAL</b> DATE SIGNED <b>2/20/59.</b>			
ACTUAL SIGNATURE <b>Simon Virkutis.</b>		M.D. <b>EASTERN SHORE STATE HOSPITAL</b>	
PHYSICIAN'S NAME (Type) <b>SIMON VIRKUTIS.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/23/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>New Bern Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>New Bern, N.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Le Crumpke Funeral Home</b>		24a. REC'D BY REGISTRAR <b>FEB 24 '59</b>	
ADDRESS <b>Cambridge Md</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hana</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1880

Name of Deceased		Age		Sex		Color		Married		Occupation	
John Doe		45		Male		White		Single		Farmer	
Date of Death		Place of Death		Cause of Death		Time of Death		Manner of Death		Buried	
Jan 15 1880		At Home		Heart Disease		10 AM		Natural		Yes	
Signature of Physician		Signature of Minister		Signature of Coroner		Signature of Registrar		Signature of Witnesses		Signature of Deceased	
J. B. Smith		W. H. Jones		C. D. Brown		E. F. Green		G. H. White		I. J. Black	
Date of Certificate		Place of Certificate		Cause of Certificate		Time of Certificate		Manner of Certificate		Buried	
Jan 15 1880		At Home		Heart Disease		10 AM		Natural		Yes	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items .3, .14 Film G240 3-18-59 et

1816

## CERTIFICATE OF DEATH

Reg. Dist. No.

01826

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2040.2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Hospital</u>				d. STREET ADDRESS <u>113 Higgins</u>			
3. NAME OF DECEASED (Type or print) First <u>Elsie</u> Middle <u>G</u> Last <u>Earle</u>				4. DATE OF DEATH Month <u>2</u> Day <u>10</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1893</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT Address <u>Mrs. Sillian Lockum, Dover Del.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Cardiac decompensation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary heart disease (atherosclerosis)</u> DUE TO <u>  </u> (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>About 7 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>59</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1</u> , 19 <u>58</u> , to <u>Feb 10</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Feb 10</u> , 19 <u>59</u> , and that death occurred at <u>  </u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. Edwin Fassett</u>				ADDRESS (Street, city or town, state) <u>Cambridge, Md.</u>			
PHYSICIAN'S NAME (Type) <u>J. Edwin Fassett, M.D.</u>				DATE SIGNED <u>3-27-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-14-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Richards Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Easton Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Dashiell</u>				ADDRESS <u>Easton, Md.</u>			
24a. REC'D BY REGISTRAR <u>  </u>				24b. REGISTRAR'S SIGNATURE <u>  </u>			
DATE <u>FEB 16 59</u>							



# 1817 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

01827

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. LENGTH OF STAY IN 1b <u>15 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge-Maryland Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Wiley</u> Middle <u>Floyd</u> Last <u>Floyd</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>15</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 4, 1904</u>	
9. AGE (In years lost birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>11</u>		IF UNDER 24 HRS. Hours <u>11</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Lumbering</u>		11. BIRTHPLACE (State or foreign country) <u>Tifton, Georgia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Frank Floyd</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Johns</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>256-09-2916</u>		17. INFORMANT <u>Mary Stanley, Cambridge, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of the Colon</u> 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 4, 1959</u> , to <u>Feb 15, 1959</u> , that I last saw the deceased alive on <u>Feb 14, 1959</u> , and that death occurred at <u>7:00 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Hilton H. Wilson</u> M.D.				ADDRESS (Street, city or town, state) <u>Cambridge, Md.</u> DATE SIGNED <u>2/18/59</u>			
PHYSICIAN'S NAME (Type) <u>HILTON H. WILSON, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/18/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Waugh Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert M. St. Clair, Jr.</u>				ADDRESS <u>Cambridge, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 24 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Clara S. Frank</u>			

CERTIFICATE OF DEATH

1917

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
John Doe		Male		45		Jan 1, 1872		Maryland		Farmer		Married		White	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH		13. DISEASE		14. PRESENT ILLNESS		15. PREVIOUS ILLNESS		16. MEDICAL ATTENDANCE	
Jan 15, 1917		10:00 AM		Home		Heart Failure		Hypertension		Stroke		None		Physician	
17. SIGNATURE OF DECEASED		18. SIGNATURE OF WITNESSES		19. SIGNATURE OF PHYSICIAN		20. SIGNATURE OF CLERK		21. SIGNATURE OF REGISTRAR		22. SIGNATURE OF JUDGE		23. SIGNATURE OF SHERIFF		24. SIGNATURE OF CORONER	
25. COUNTY		26. CITY		27. STATE		28. ZIP CODE		29. COUNTY		30. CITY		31. STATE		32. ZIP CODE	
Baltimore		Baltimore		Maryland		21201		Baltimore		Baltimore		Maryland		21201	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1831

## CERTIFICATE OF DEATH

01828

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Cambridge</b>		c. LENGTH OF STAY IN 1b <b>Cambridge 13</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eastern Shore State Hospital</b>		d. STREET ADDRESS <b>56 Glasgow</b>	
3. NAME OF DECEASED (Type or print) <b>ERNEST J. Gore</b>		4. DATE OF DEATH Month <b>Feb</b> Day <b>12</b> Year <b>1959</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan 2 1885</b>
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Wholesale Grocer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Grocery</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Gore</b>		14. MOTHER'S MAIDEN NAME <b>Emma Robbins</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Eastern Shore State Hospital records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>General Arteriosclerosis</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>UNK</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>Jan 10</b> , 1959, to <b>Feb 12</b> , 1959, that I last saw the deceased alive on <b>Feb 12</b> , 1959, and that death occurred at <b>3:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <b>Thomas J. Dredge</b> M.D. <b>E.S.S. Hospital, Cambridge, Md. 2-12-59</b> PHYSICIAN'S NAME (Type) <b>Thomas J. Dredge</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/15/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Men. Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Le Compte Funeralservice</b>		24a. REC'D BY REGISTRAR <b>DATE 17 '59</b>	
ADDRESS <b>Cambridge, Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Huns</b>	



1832

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Cambridge</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Smithtown Shidley 23X-2</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eastern Shore State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>William Henry Gray</b>			4. DATE OF DEATH Month <b>Feb</b> Day <b>8</b> Year <b>1959</b>				
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov 29 1885</b>		9. AGE (In years last birthday) <b>73</b> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Simplex Co</b>			11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>John A. Gray</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>Eastern Shore State Hospital records</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>General Arteriosclerosis</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>Unk</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1</b> , 1953, to <b>Feb 8</b> , 1959, that I last saw the deceased alive on <b>Feb 7</b> , 1959, and that death occurred at <b>2:50 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Thomas J. Dredge</b> M.D.				ADDRESS (Street, city or town, state) <b>State Hospital Cambridge Md</b> DATE SIGNED <b>2-8-59</b>			
PHYSICIAN'S NAME (Type) <b>Thomas J. Dredge, M.D.</b>				ADDRESS <b>Eastern Shore State Hospital, Cambridge, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>Feb 11/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Trinity Methodist Cemetery Shidley, Maryland</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Thomas J. Dredge</b>				ADDRESS <b>State Hospital</b>		24a. REC'D BY REGISTRAR <b>DATE 11/59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>			

CERTIFICATE OF DEATH

1932

1. NAME OF DECEASED <i>JOHN J. JONES</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. PLACE OF BIRTH <i>St. Louis, Mo.</i>		5. DATE OF BIRTH <i>Jan. 15, 1887</i>		6. PLACE OF DEATH <i>St. Louis, Mo.</i>	
7. OCCUPATION <i>Engineer</i>		8. CAUSE OF DEATH <i>Heart Disease</i>		9. MANNER OF DEATH <i>Natural</i>	
10. DATE OF DEATH <i>Jan. 15, 1932</i>		11. TIME OF DEATH <i>10:30 A.M.</i>		12. PLACE OF INTERMENT <i>St. Louis, Mo.</i>	
13. SIGNATURE OF DECEASED <i>John J. Jones</i>		14. SIGNATURE OF WITNESSES <i>John J. Jones</i>		15. SIGNATURE OF DECEASED <i>John J. Jones</i>	
16. SIGNATURE OF DECEASED <i>John J. Jones</i>		17. SIGNATURE OF WITNESSES <i>John J. Jones</i>		18. SIGNATURE OF DECEASED <i>John J. Jones</i>	
19. SIGNATURE OF DECEASED <i>John J. Jones</i>		20. SIGNATURE OF WITNESSES <i>John J. Jones</i>		21. SIGNATURE OF DECEASED <i>John J. Jones</i>	
22. SIGNATURE OF DECEASED <i>John J. Jones</i>		23. SIGNATURE OF WITNESSES <i>John J. Jones</i>		24. SIGNATURE OF DECEASED <i>John J. Jones</i>	
25. SIGNATURE OF DECEASED <i>John J. Jones</i>		26. SIGNATURE OF WITNESSES <i>John J. Jones</i>		27. SIGNATURE OF DECEASED <i>John J. Jones</i>	
28. SIGNATURE OF DECEASED <i>John J. Jones</i>		29. SIGNATURE OF WITNESSES <i>John J. Jones</i>		30. SIGNATURE OF DECEASED <i>John J. Jones</i>	
31. SIGNATURE OF DECEASED <i>John J. Jones</i>		32. SIGNATURE OF WITNESSES <i>John J. Jones</i>		33. SIGNATURE OF DECEASED <i>John J. Jones</i>	
34. SIGNATURE OF DECEASED <i>John J. Jones</i>		35. SIGNATURE OF WITNESSES <i>John J. Jones</i>		36. SIGNATURE OF DECEASED <i>John J. Jones</i>	
37. SIGNATURE OF DECEASED <i>John J. Jones</i>		38. SIGNATURE OF WITNESSES <i>John J. Jones</i>		39. SIGNATURE OF DECEASED <i>John J. Jones</i>	
40. SIGNATURE OF DECEASED <i>John J. Jones</i>		41. SIGNATURE OF WITNESSES <i>John J. Jones</i>		42. SIGNATURE OF DECEASED <i>John J. Jones</i>	
43. SIGNATURE OF DECEASED <i>John J. Jones</i>		44. SIGNATURE OF WITNESSES <i>John J. Jones</i>		45. SIGNATURE OF DECEASED <i>John J. Jones</i>	
46. SIGNATURE OF DECEASED <i>John J. Jones</i>		47. SIGNATURE OF WITNESSES <i>John J. Jones</i>		48. SIGNATURE OF DECEASED <i>John J. Jones</i>	
49. SIGNATURE OF DECEASED <i>John J. Jones</i>		50. SIGNATURE OF WITNESSES <i>John J. Jones</i>		51. SIGNATURE OF DECEASED <i>John J. Jones</i>	
52. SIGNATURE OF DECEASED <i>John J. Jones</i>		53. SIGNATURE OF WITNESSES <i>John J. Jones</i>		54. SIGNATURE OF DECEASED <i>John J. Jones</i>	
55. SIGNATURE OF DECEASED <i>John J. Jones</i>		56. SIGNATURE OF WITNESSES <i>John J. Jones</i>		57. SIGNATURE OF DECEASED <i>John J. Jones</i>	
58. SIGNATURE OF DECEASED <i>John J. Jones</i>		59. SIGNATURE OF WITNESSES <i>John J. Jones</i>		60. SIGNATURE OF DECEASED <i>John J. Jones</i>	
61. SIGNATURE OF DECEASED <i>John J. Jones</i>		62. SIGNATURE OF WITNESSES <i>John J. Jones</i>		63. SIGNATURE OF DECEASED <i>John J. Jones</i>	
64. SIGNATURE OF DECEASED <i>John J. Jones</i>		65. SIGNATURE OF WITNESSES <i>John J. Jones</i>		66. SIGNATURE OF DECEASED <i>John J. Jones</i>	
67. SIGNATURE OF DECEASED <i>John J. Jones</i>		68. SIGNATURE OF WITNESSES <i>John J. Jones</i>		69. SIGNATURE OF DECEASED <i>John J. Jones</i>	
70. SIGNATURE OF DECEASED <i>John J. Jones</i>		71. SIGNATURE OF WITNESSES <i>John J. Jones</i>		72. SIGNATURE OF DECEASED <i>John J. Jones</i>	
73. SIGNATURE OF DECEASED <i>John J. Jones</i>		74. SIGNATURE OF WITNESSES <i>John J. Jones</i>		75. SIGNATURE OF DECEASED <i>John J. Jones</i>	
76. SIGNATURE OF DECEASED <i>John J. Jones</i>		77. SIGNATURE OF WITNESSES <i>John J. Jones</i>		78. SIGNATURE OF DECEASED <i>John J. Jones</i>	
79. SIGNATURE OF DECEASED <i>John J. Jones</i>		80. SIGNATURE OF WITNESSES <i>John J. Jones</i>		81. SIGNATURE OF DECEASED <i>John J. Jones</i>	
82. SIGNATURE OF DECEASED <i>John J. Jones</i>		83. SIGNATURE OF WITNESSES <i>John J. Jones</i>		84. SIGNATURE OF DECEASED <i>John J. Jones</i>	
85. SIGNATURE OF DECEASED <i>John J. Jones</i>		86. SIGNATURE OF WITNESSES <i>John J. Jones</i>		87. SIGNATURE OF DECEASED <i>John J. Jones</i>	
88. SIGNATURE OF DECEASED <i>John J. Jones</i>		89. SIGNATURE OF WITNESSES <i>John J. Jones</i>		90. SIGNATURE OF DECEASED <i>John J. Jones</i>	
91. SIGNATURE OF DECEASED <i>John J. Jones</i>		92. SIGNATURE OF WITNESSES <i>John J. Jones</i>		93. SIGNATURE OF DECEASED <i>John J. Jones</i>	
94. SIGNATURE OF DECEASED <i>John J. Jones</i>		95. SIGNATURE OF WITNESSES <i>John J. Jones</i>		96. SIGNATURE OF DECEASED <i>John J. Jones</i>	
97. SIGNATURE OF DECEASED <i>John J. Jones</i>		98. SIGNATURE OF WITNESSES <i>John J. Jones</i>		99. SIGNATURE OF DECEASED <i>John J. Jones</i>	
100. SIGNATURE OF DECEASED <i>John J. Jones</i>		101. SIGNATURE OF WITNESSES <i>John J. Jones</i>		102. SIGNATURE OF DECEASED <i>John J. Jones</i>	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1833

## CERTIFICATE OF DEATH

Reg. Dist. No.

01833

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RFD # 3 Cambridge</b> c. LENGTH OF STAY IN 1b <b>Life</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> d. STREET ADDRESS <b>RFD # 3</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Joseph Henry James</b>		4. DATE OF DEATH Month <b>Feb</b> Day <b>14</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec 27 1873</b> 9. AGE (In years last birthday) <b>85 7/8</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>John W James</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ann Pritchard</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Miss Clara James</b>		Address <b>Cambridge Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY HEART DISEASE</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROSIS</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>TERMINAL BRONCHO PNEUMONIA</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>12-13-52</b> , 19____, to <b>2-14-59</b> , 19____, that I last saw the deceased alive on <b>2-14-59</b> , 19____, and that death occurred at <b>4:55P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>200 Maryland Ave.</b> DATE SIGNED <b>2-17-59</b> ACTUAL SIGNATURE <b>Albert E. Bunker</b> PHYSICIAN'S NAME (Type) <b>Albert E. Bunker, M. D.</b> <b>Cambridge, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb 17, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill</b>	22d. LOCATION (City, town, or county) (State) <b>Easton Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>LeCompte Funeral Service</b>		ADDRESS <b>Cambridge Maryland</b>	24a. REC'D BY REGISTRAR <b>FEB 18 59</b>
		24b. REGISTRAR'S SIGNATURE <b>Charles S. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1818  
CERTIFICATE OF DEATH

01832

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>	c. LENGTH OF STAY IN 1b <u>40 years</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>13 Cambridge</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge-Maryland Hospital</u>		d. STREET ADDRESS <u>9 High Street</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Harlan</u> Middle <u>Goldsborough</u> Last <u>Johnson</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>14</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 12, 1900</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance Broker</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>Toddville, Dor. Co.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Goldsborough Johnson</u>	
14. MOTHER'S MAIDEN NAME <u>Augusta Robinson</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>217-07-7751</u>		17. INFORMANT <u>Mrs. Katherine C. Johnson, 9 High St., Cambridge, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cirrhosis Liver</u> <u>581.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>30 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute Hepatitis</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>1/10</u> , 19 <u>59</u> , to <u>2/14</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2/14</u> , 19 <u>59</u> , and that death occurred at <u>6.00</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. H. Hanks</u> M.D.		ADDRESS (Street, city or town, state) <u>104 Locust St. Cambridge, Md.</u>	
PHYSICIAN'S NAME (Type) <u>W. H. Hanks</u>		DATE SIGNED <u>2/16/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb. 17, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Cambridge, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Reineth K. Thomas</u>		24a. REC'D BY REGISTRAR <u>FEB 18 59</u>	
ADDRESS <u>Cambridge, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DECEASED

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1834

CERTIFICATE OF DEATH

01833

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Cambridge</b>				c. LENGTH OF STAY IN 1b <b>32 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wye Mills</b> 17x-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eastern Shore State Hospital</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>HATTIE LLOYD</b>				4. DATE OF DEATH Month Day Year <b>Feb 27 1959</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 10, 1899</b>	9. AGE (In years last birthday) yrs. <b>59</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Md Wye Mills</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George MILES</b>				14. MOTHER'S MAIDEN NAME <b>Carrie Abbott</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>Eastern Shore State Hospital records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>Unk</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1</b> , 1953, to <b>Feb 27</b> , 1959, that I last saw the deceased alive on <b>Feb 26</b> , 1959, and that death occurred at <b>5:35 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Thomas J. Dredge M.D. E.S.S. Hospital, Cambridge, Md. 2-27-59</b>							
ACTUAL SIGNATURE <b>Thomas J. Dredge</b>				PHYSICIAN'S NAME (Type) <b>Thomas J. Dredge</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>March 2, 1959</b>		<b>Woodlawn Memorial Park, Inc.</b>		<b>Eastern Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>James H. Bartley of Bartley Bros. Centerville, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 5 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

CERTIFICATE OF DEATH

1934

1. NAME OF DECEASED <b>JOHN J. BROWN</b>		2. SEX <b>MALE</b>	
3. AGE <b>45</b>		4. DATE OF BIRTH <b>1889</b>	
5. PLACE OF BIRTH <b>NEW YORK</b>		6. OCCUPATION <b>LABORER</b>	
7. MARITAL STATUS <b>MARRIED</b>		8. DATE OF MARRIAGE <b>1915</b>	
9. NAME OF SPOUSE <b>MARY J. BROWN</b>		10. DATE OF DEATH <b>1934</b>	
11. PLACE OF DEATH <b>HOME</b>		12. CAUSE OF DEATH <b>HEART DISEASE</b>	
13. MEDICAL HISTORY <b>None</b>		14. PRESENT ILLNESS <b>None</b>	
15. SIGNATURE OF PHYSICIAN <b>[Signature]</b>		16. SIGNATURE OF REGISTRAR <b>[Signature]</b>	
17. SIGNATURE OF WITNESS <b>[Signature]</b>		18. SIGNATURE OF DECEASED <b>[Signature]</b>	
19. SIGNATURE OF DECEASED <b>[Signature]</b>		20. SIGNATURE OF DECEASED <b>[Signature]</b>	
21. SIGNATURE OF DECEASED <b>[Signature]</b>		22. SIGNATURE OF DECEASED <b>[Signature]</b>	
23. SIGNATURE OF DECEASED <b>[Signature]</b>		24. SIGNATURE OF DECEASED <b>[Signature]</b>	
25. SIGNATURE OF DECEASED <b>[Signature]</b>		26. SIGNATURE OF DECEASED <b>[Signature]</b>	
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33. SIGNATURE OF DECEASED <b>[Signature]</b>		34. SIGNATURE OF DECEASED <b>[Signature]</b>	
35. SIGNATURE OF DECEASED <b>[Signature]</b>		36. SIGNATURE OF DECEASED <b>[Signature]</b>	
37. SIGNATURE OF DECEASED <b>[Signature]</b>		38. SIGNATURE OF DECEASED <b>[Signature]</b>	
39. SIGNATURE OF DECEASED <b>[Signature]</b>		40. SIGNATURE OF DECEASED <b>[Signature]</b>	
41. SIGNATURE OF DECEASED <b>[Signature]</b>		42. SIGNATURE OF DECEASED <b>[Signature]</b>	
43. SIGNATURE OF DECEASED <b>[Signature]</b>		44. SIGNATURE OF DECEASED <b>[Signature]</b>	
45. SIGNATURE OF DECEASED <b>[Signature]</b>		46. SIGNATURE OF DECEASED <b>[Signature]</b>	
47. SIGNATURE OF DECEASED <b>[Signature]</b>		48. SIGNATURE OF DECEASED <b>[Signature]</b>	
49. SIGNATURE OF DECEASED <b>[Signature]</b>		50. SIGNATURE OF DECEASED <b>[Signature]</b>	
51. SIGNATURE OF DECEASED <b>[Signature]</b>		52. SIGNATURE OF DECEASED <b>[Signature]</b>	
53. SIGNATURE OF DECEASED <b>[Signature]</b>		54. SIGNATURE OF DECEASED <b>[Signature]</b>	
55. SIGNATURE OF DECEASED <b>[Signature]</b>		56. SIGNATURE OF DECEASED <b>[Signature]</b>	
57. SIGNATURE OF DECEASED <b>[Signature]</b>		58. SIGNATURE OF DECEASED <b>[Signature]</b>	
59. SIGNATURE OF DECEASED <b>[Signature]</b>		60. SIGNATURE OF DECEASED <b>[Signature]</b>	
61. SIGNATURE OF DECEASED <b>[Signature]</b>		62. SIGNATURE OF DECEASED <b>[Signature]</b>	
63. SIGNATURE OF DECEASED <b>[Signature]</b>		64. SIGNATURE OF DECEASED <b>[Signature]</b>	
65. SIGNATURE OF DECEASED <b>[Signature]</b>		66. SIGNATURE OF DECEASED <b>[Signature]</b>	
67. SIGNATURE OF DECEASED <b>[Signature]</b>		68. SIGNATURE OF DECEASED <b>[Signature]</b>	
69. SIGNATURE OF DECEASED <b>[Signature]</b>		70. SIGNATURE OF DECEASED <b>[Signature]</b>	
71. SIGNATURE OF DECEASED <b>[Signature]</b>		72. SIGNATURE OF DECEASED <b>[Signature]</b>	
73. SIGNATURE OF DECEASED <b>[Signature]</b>		74. SIGNATURE OF DECEASED <b>[Signature]</b>	
75. SIGNATURE OF DECEASED <b>[Signature]</b>		76. SIGNATURE OF DECEASED <b>[Signature]</b>	
77. SIGNATURE OF DECEASED <b>[Signature]</b>		78. SIGNATURE OF DECEASED <b>[Signature]</b>	
79. SIGNATURE OF DECEASED <b>[Signature]</b>		80. SIGNATURE OF DECEASED <b>[Signature]</b>	
81. SIGNATURE OF DECEASED <b>[Signature]</b>		82. SIGNATURE OF DECEASED <b>[Signature]</b>	
83. SIGNATURE OF DECEASED <b>[Signature]</b>		84. SIGNATURE OF DECEASED <b>[Signature]</b>	
85. SIGNATURE OF DECEASED <b>[Signature]</b>		86. SIGNATURE OF DECEASED <b>[Signature]</b>	
87. SIGNATURE OF DECEASED <b>[Signature]</b>		88. SIGNATURE OF DECEASED <b>[Signature]</b>	
89. SIGNATURE OF DECEASED <b>[Signature]</b>		90. SIGNATURE OF DECEASED <b>[Signature]</b>	
91. SIGNATURE OF DECEASED <b>[Signature]</b>		92. SIGNATURE OF DECEASED <b>[Signature]</b>	
93. SIGNATURE OF DECEASED <b>[Signature]</b>		94. SIGNATURE OF DECEASED <b>[Signature]</b>	
95. SIGNATURE OF DECEASED <b>[Signature]</b>		96. SIGNATURE OF DECEASED <b>[Signature]</b>	
97. SIGNATURE OF DECEASED <b>[Signature]</b>		98. SIGNATURE OF DECEASED <b>[Signature]</b>	
99. SIGNATURE OF DECEASED <b>[Signature]</b>		100. SIGNATURE OF DECEASED <b>[Signature]</b>	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

1835

01834

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Cambridge</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury 22x-2</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eastern Shore State Hospital</b>				d. STREET ADDRESS <b>RT 1</b>			
3. NAME OF DECEASED (Type or print) First <b>Margie</b> Middle <b>ELLEN</b> Last <b>Malone</b>				4. DATE OF DEATH Month <b>Feb</b> Day <b>22</b> Year <b>1959</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 21 1891</b>	9. AGE (In years last birthday) <b>67</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md Siloam, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Hilghman</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Brumley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>Mr. Elwood Malone (Son) R.D.#1 Salisbury, Md. Eastern Shore State Hospital records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocardial</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Degeneration</b> (c) <b>Unk</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>Feb 1</b> , 19 <b>53</b> , to <b>Feb 22</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Feb 22</b> , 19 <b>59</b> , and that death occurred at <b>8:15 P.</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Thomas J. Dredge</b> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <b>E.S.S. Hospital, Cambridge, Md. 2-22-59</b>			
PHYSICIAN'S NAME (Type) <b>Thomas J. Dredge</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 25, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Siloam Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Siloam, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>				ADDRESS <b>SALISBURY MARYLAND</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 24 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>			



CERTIFICATE OF DEATH

Reg. 5011-11a

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH 12-5-29		5. PLACE OF BIRTH MOBILE, ALA.	
6. OCCUPATION Attorney		7. MARITAL STATUS Single		8. COLOR White		9. RELIGION Methodist		10. EDUCATION High School	
11. CAUSE OF DEATH Suicide		12. MANNER OF DEATH Homicide		13. PLACE OF DEATH Baltimore, Md.		14. TIME OF DEATH 11:00 AM		15. DATE OF DEATH 4-4-68	
16. SIGNATURE OF PHYSICIAN J. Edgar Hoover		17. SIGNATURE OF CORONER J. Edgar Hoover		18. SIGNATURE OF WITNESS J. Edgar Hoover		19. SIGNATURE OF DECEASED J. Edgar Hoover		20. SIGNATURE OF NEXT OF KIN J. Edgar Hoover	
21. SIGNATURE OF REGISTRAR J. Edgar Hoover		22. SIGNATURE OF CLERK J. Edgar Hoover		23. SIGNATURE OF CHIEF OF BUREAU J. Edgar Hoover		24. SIGNATURE OF ASSISTANT CHIEF OF BUREAU J. Edgar Hoover		25. SIGNATURE OF DEPUTY CHIEF OF BUREAU J. Edgar Hoover	



# 1 M 67 1819 01835 Reg. Dist. No. 1819 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> c. LENGTH OF STAY IN b <b>2 Weeks</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cambridge Maryland Hosp.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>13 Cambridge</b> d. STREET ADDRESS <b>Pleasant Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Harvey T. Meredith</b>				4. DATE OF DEATH Month Day Year <b>Feb. 9. 1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1876</b> About <b>83</b> yrs.	
9. AGE (In years last birthday)		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Seafood</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>Lambert Meredith</b>		14. MOTHER'S MAIDEN NAME <b>Hester J. Meredith</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs Edgar Cusick</b>		Address <b>Cambridge Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Chronic hypertrophic Osteo-arthritis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic hypertrophic Osteo-arthritis</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Cambridge</b>		(County) <b>Maryland</b>		(State) <b>Maryland</b>	
21. I certify that I attended the deceased from <b>1/20</b> , 19 <b>59</b> , to <b>2/9</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Feb 8</b> , 19 <b>59</b> , and that death occurred at <b>12:30</b> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Albert E. Bunker</b>		M.D. <b>200 Maryland Ave.</b>		ADDRESS (Street, city or town, state) <b>Cambridge, Maryland</b>		DATE SIGNED <b>2/10/59</b>	
PHYSICIAN'S NAME (Type) <b>Albert E. Bunker, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 11 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Zion Church Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Toddville Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>LeCompte Funeral Service</b>				ADDRESS <b>Cambridge Maryland</b>		24a. REC'D BY REGISTRAR <b>FEB 11 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knaus</b>			

CERTIFICATE OF DEATH

Form No. 1

FILE NO.

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

DATE OF DEPARTURE

DATE OF RETURN

DATE OF DEATH

DATE OF BURIAL

DATE OF CREMATION

DATE OF INTERMENT

DATE OF EXHUMATION

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1836 CERTIFICATE OF DEATH

01836

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lincoln Road</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lincoln Road</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Stange</u> Last <u>Molock</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>10</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 5, 1890</u>		9. AGE (In years last birthday) <u>68</u> yrs.	10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Food Packing</u>		11. BIRTHPLACE (State or foreign country) <u>Dorchester Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ned Molock</u>				14. MOTHER'S MAIDEN NAME <u>Annie Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-02-0304</u>		17. INFORMANT Address <u>Alvin Molock, Lincoln Road, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January</u> , 19 <u>57</u> to <u>February 10</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>February 10</u> , 19 <u>59</u> , and that death occurred at <u>  </u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. Edwin Fassett</u>				ADDRESS (Street, city or town, state) <u>227 Pine St-Cambridge, Md.</u>		DATE SIGNED <u>2-13-59</u>	
PHYSICIAN'S NAME (Type) <u>J. Edwin Fassett, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/15/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Road Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Dorchester County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard M. Stiles Jr.</u>				ADDRESS <u>Cambridge, Md.</u>		24a. REC'D BY REGISTRAR <u>Feb 16 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hearn</u>			

CERTIFICATE OF DEATH

1836

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH	
5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH	
9. TIME OF DEATH		10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF WITNESSES		12. SIGNATURE OF REGISTRAR	
13. NAME OF FUNERAL HOME		14. NAME OF MINISTER		15. NAME OF CHURCH		16. NAME OF CEMETERY	
17. NAME OF UNDERTAKER		18. NAME OF BURIAL		19. NAME OF CREMATION		20. NAME OF INTERMENT	
21. NAME OF INTERMENT		22. NAME OF INTERMENT		23. NAME OF INTERMENT		24. NAME OF INTERMENT	
25. NAME OF INTERMENT		26. NAME OF INTERMENT		27. NAME OF INTERMENT		28. NAME OF INTERMENT	
29. NAME OF INTERMENT		30. NAME OF INTERMENT		31. NAME OF INTERMENT		32. NAME OF INTERMENT	
33. NAME OF INTERMENT		34. NAME OF INTERMENT		35. NAME OF INTERMENT		36. NAME OF INTERMENT	
37. NAME OF INTERMENT		38. NAME OF INTERMENT		39. NAME OF INTERMENT		40. NAME OF INTERMENT	
41. NAME OF INTERMENT		42. NAME OF INTERMENT		43. NAME OF INTERMENT		44. NAME OF INTERMENT	
45. NAME OF INTERMENT		46. NAME OF INTERMENT		47. NAME OF INTERMENT		48. NAME OF INTERMENT	
49. NAME OF INTERMENT		50. NAME OF INTERMENT		51. NAME OF INTERMENT		52. NAME OF INTERMENT	
53. NAME OF INTERMENT		54. NAME OF INTERMENT		55. NAME OF INTERMENT		56. NAME OF INTERMENT	
57. NAME OF INTERMENT		58. NAME OF INTERMENT		59. NAME OF INTERMENT		60. NAME OF INTERMENT	
61. NAME OF INTERMENT		62. NAME OF INTERMENT		63. NAME OF INTERMENT		64. NAME OF INTERMENT	
65. NAME OF INTERMENT		66. NAME OF INTERMENT		67. NAME OF INTERMENT		68. NAME OF INTERMENT	
69. NAME OF INTERMENT		70. NAME OF INTERMENT		71. NAME OF INTERMENT		72. NAME OF INTERMENT	
73. NAME OF INTERMENT		74. NAME OF INTERMENT		75. NAME OF INTERMENT		76. NAME OF INTERMENT	
77. NAME OF INTERMENT		78. NAME OF INTERMENT		79. NAME OF INTERMENT		80. NAME OF INTERMENT	
81. NAME OF INTERMENT		82. NAME OF INTERMENT		83. NAME OF INTERMENT		84. NAME OF INTERMENT	
85. NAME OF INTERMENT		86. NAME OF INTERMENT		87. NAME OF INTERMENT		88. NAME OF INTERMENT	
89. NAME OF INTERMENT		90. NAME OF INTERMENT		91. NAME OF INTERMENT		92. NAME OF INTERMENT	
93. NAME OF INTERMENT		94. NAME OF INTERMENT		95. NAME OF INTERMENT		96. NAME OF INTERMENT	
97. NAME OF INTERMENT		98. NAME OF INTERMENT		99. NAME OF INTERMENT		100. NAME OF INTERMENT	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 FilmG239 2-27-59 et

## CERTIFICATE OF DEATH

1820

01837

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>				c. LENGTH OF STAY IN 1b <b>3 months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glasgow Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM T. NEAL</b>				4. DATE OF DEATH Month Day Year <b>Feb. 19, 19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 28, 1892</b>		9. AGE (In years last birthday) <b>66</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>auto mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Wm. H. Neal</b>				14. MOTHER'S MAIDEN NAME <b>Anna Virginia Winterbottom</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>220-32-0217</b>		17. INFORMANT Address <b>Mrs. W. T. Neal Easton, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of rectum</b> 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>12/11, 1958</b> to <b>2/19, 1959</b> that I last saw the deceased alive on <b>2/19, 1959</b> , and that death occurred at <b>5:30 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Lawrence Maryanov</b> M.D.				ADDRESS (Street, city or town, state) <b>136 Race St Cambridge, Md</b> DATE SIGNED <b>2/20/59</b>			
PHYSICIAN'S NAME (Type) <b>Lawrence Maryanov M.D</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 21, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Easton, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Maurice E. Newnam &amp; Son</b> ADDRESS <b>Easton, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 25 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Howard</b>	







MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1837 CERTIFICATE OF DEATH

Reg. Dist. No.

01838

1. PLACE OF DEATH o. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural Cambridge</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crisfield</u> 1939.2 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hospital</u>				d. STREET ADDRESS <u>CALVARY RD</u>			
3. NAME OF DECEASED (Type or print) <u>Carroll T. Nelson</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>23</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 27/883</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GROCERY</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ALEX T. NELSON</u>				14. MOTHER'S MAIDEN NAME <u>ISABELLE STERLING</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Eastern Shore State Hospital records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General Arteriosclerosis</u> <u>450.0</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>UNK</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 20, 1956</u> , to <u>Feb 23, 1959</u> , that I last saw the deceased alive on <u>Feb 22, 1959</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas J. Dredge</u> M.D.				ADDRESS (Street, city or town, state) <u>E.S.S. Hospital, Cambridge, Md.</u> DATE SIGNED <u>2-23-59</u>			
PHYSICIAN'S NAME (Type) <u>Thomas J. Dredge</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-24-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ASBURY CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>CRISFIELD MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BRADSHAW + SONS. CRISFIELD, MD</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 25 1959</u>		24b. REGISTRAR'S SIGNATURE <u>William E. Fisher</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1838 Item 8 Film G240 3-30-59 et

03075

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH COUNTY <u>Dorchester</u> MIDDLE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sewards</u>	c. LENGTH OF STAY IN 1b <u>Life</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sewards</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>1</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>J</u> Last <u>North</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>20</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1882</u> <u>August 15, 1882</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Seafood</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		13. FATHER'S NAME <u>James J North</u>	
14. MOTHER'S MAIDEN NAME <u>Virginia Robbins</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>215 20 1303</u>		17. INFORMANT <u>Russell North</u> Address <u>Cambridge Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiomegally and myocardial malacia</u> <u>434.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Mace Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>3/20/59</u>	
EXAMINER'S NAME (Type) <u>Dr. John Mace Jr.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb 22, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn</u>	22d. LOCATION (City, town, or county) (State) <u>Cambridge Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>		ADDRESS <u>Cambridge Maryland</u>	
24a. REC'D BY REGISTRAR <u>MAR 24 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hunt</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1821

CERTIFICATE OF DEATH

01839

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mardela (Rural)</b> <b>22X-2</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cambridge Md Gen. Hospital</b>				d. STREET ADDRESS <b>R.D.#</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>LEWIS</b> Middle <b>ADDISON</b> Last <b>PHILLIPS</b>				4. DATE OF DEATH Month <b>February</b> Day <b>11</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 29, 1886</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>12</b>		11. IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Mardela, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>William Spencer Phillips</b>				14. MOTHER'S MAIDEN NAME <b>Charlotte Horseman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>INFORMANT Mrs. Letitia E. Phillips R.D.# Mardela, Maryland</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>443X</b> DUE TO <b>Cerebral Hemorrhage</b> <b>Hypertensive Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>3 days 1 yr.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>2/11/59</b> , 19 <b>59</b> , to <b>2/11/59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>2/11/59</b> , 19 <b>59</b> , and that death occurred at <b>11:45 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>136 Race St. Cambridge, Maryland</b> DATE SIGNED <b>Feb. 13 /1959</b>							
ACTUAL SIGNATURE <b>Dr. Lawrence Maryanov</b>				PHYSICIAN'S NAME (Type) <b>Dr. Lawrence Maryanov</b> <b>136 Race St. Cambridge, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 14, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mardela Cemetery (New Part)</b>		22d. LOCATION (City, town, or county) (State) <b>Mardela, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b> ADDRESS <b>SALISBURY MARYLAND</b>				24a. REC'D BY REGISTRAR <b>DATE FEB 16 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

67

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Dr

1931

Correspondence

Cambridge

Cambridge, Mass. U.S.A.

ATLANTIC

White

Western Union

William Brewster Phillips

Cambridge, Massachusetts

New York, N.Y. U.S.A.

U.S.A. Western Union

Experimental Heat Dissipation  
3 days

1931

Dec. 13 1931

106 and St. Cambridge, Mass.

Cambridge, Mass.

Cambridge, Mass. U.S.A.

HOLWAY & COMPANY, MILLBURY, MASS.



1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
1822 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 01840

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge, Md.</b>	c. LENGTH OF STAY IN 1b <b>1 Hr.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Linkwood</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cambridge, Maryland Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Louise Thompson Pinder</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>2,</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April, 12, 1913</b>
9. AGE (In years last birthday) <b>45</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Lewis Thompson</b>	
14. MOTHER'S MAIDEN NAME <b>Ollie Wilson</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Monroe Pinder</b> Address <b>Linkwood, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident.</b> <b>331x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hrs.</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Dr. John Mace Jr.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>2/6/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/5/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Bucktown Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Nr. Vienna, Dor. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Herbert St. Clair</b>		ADDRESS <b>Cambridge, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>FEB 13 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Orville L. Kiana</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK



OFFICE OF THE  
COMMISSIONER OF HEALTH

1892 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Form with multiple sections for medical examination and death certification, including fields for name, age, sex, cause of death, and examiner's signature.

NAME: \_\_\_\_\_

AGE: \_\_\_\_\_ SEX: \_\_\_\_\_

CAUSE OF DEATH: \_\_\_\_\_

EXAMINER'S SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1839

## CERTIFICATE OF DEATH

01841

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Cambridge</b>				c. LENGTH OF STAY IN 1b <b>Princess Anne 19X-2</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Eastern Shore State Hospital</b>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <b>Orlando M. Ruark</b>				4. DATE OF DEATH Month <b>Feb</b> Day <b>7</b> Year <b>1959</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct 1 1882</b>	9. AGE (In years) <b>76</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Peter Ruark</b>				14. MOTHER'S MAIDEN NAME <b>Mary Ruark</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Eastern Shore State Hospital records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho-Pneumonia</b> <b>491X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <b>Unk</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan 12, 1959</b> , to <b>Feb 7, 1959</b> , that I last saw the deceased alive on <b>Feb 7, 1959</b> , and that death occurred at <b>10:40 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Thomas J. Dredge</b> M.D.				ADDRESS (Street, city or town, state) <b>State Hospital Cambridge Md</b> DATE SIGNED <b>2-7-59</b>			
PHYSICIAN'S NAME (Type) <b>Thomas J. Dredge, M.D.</b>				Eastern Shore State Hospital, Cambridge, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-10-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Friendship Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Near Princess Anne Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Levin B. Wilson</b>				ADDRESS <b>Princess Anne Md</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	
24a. REC'D BY REGISTRAR <b>FEB 13 '59</b>				DATE			

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1840

CERTIFICATE OF DEATH

01842

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>7-6-67</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Cambridge</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oxford</b> 20X-2		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eastern Shore State Hospital</b>		d. STREET ADDRESS <b>✓</b>		
3. NAME OF DECEASED (Type or print) <b>John</b> First <b>Thomas</b> Middle <b>Russell</b> Last		4. DATE OF DEATH <b>Feb 27 1959</b> Month <b>Feb</b> Day <b>27</b> Year <b>1959</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1882</b>	
9. AGE (In years last birthday) <b>76</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>Md</b>		
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>George Russell</b>		14. MOTHER'S MAIDEN NAME <b>Liza - Unknown</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>20</b>		
17. INFORMANT <b>Eastern Shore State Hospital records</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>General Arteriosclerosis</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <b>UNK</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>Jan 28, 1959</b> , to <b>Feb 27, 1959</b> , that I last saw the deceased alive on <b>Feb 27, 1959</b> , and that death occurred at <b>5:45 P.M.</b> , from the causes and on the date stated above.				
ACTUAL SIGNATURE <b>Thomas J. Dredge</b> M.D.		ADDRESS (Street, city or town, state) <b>E.S.S. Hospital, Cambridge, Md. 2-27-59</b>		
PHYSICIAN'S NAME (Type) <b>Thomas J. Dredge</b>		DATE SIGNED		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb 3, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Oxford</b>	22d. LOCATION (City, town, or county) (State) <b>Oxford Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Thurice E. Newman, Jr.</b> ADDRESS <b>Easton Md.</b>		24a. REC'D BY REGISTRAR <b>DATE MAR 2 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

MEDICAL CERTIFICATION





FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01843

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>2 mo. 9 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalsburg</u> <u>05X-2</u> ✓	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>			d. STREET ADDRESS <u>---</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Chester</u> Middle <u>Auther</u> Last <u>Scott</u>			4. DATE OF DEATH Month <u>February</u> Day <u>2</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 5, 1883</u>		9. AGE (in years last birthday) <u>75</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>John Scott</u>			14. MOTHER'S MAIDEN NAME <u>Meg Sullivan</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>---</u>	17. INFORMANT <u>RECORDS: Eastern Shore State Hospital</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>Few Min.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Federalsburg</u>	(County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>John Mace Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>2/2/59</u>	
EXAMINER'S NAME (Type) <u>John Mace Jr.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-5-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cem.</u>		22d. LOCATION (City, town, or county) <u>Federalsburg, Md.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Harvey Williamson</u>		ADDRESS		24a. REC'D BY REGISTRAR DATE <u>FEB 9 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Turner</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
1823  
CERTIFICATE OF DEATH**

03082

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMbridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMbridge</u>	
c. LENGTH OF STAY IN 1b <u>8 years</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CAMbridge Md Hospital</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		STREET ADDRESS <u>CAMbridge Md.</u>	
3. NAME OF DECEASED (Type or print) <u>Joe</u> First <u>Smith</u> Last		4. DATE OF DEATH Month <u>2</u> Day <u>23</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-16-1917</u>
9. AGE (In years last birthday) <u>41</u> yrs.		10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>UNKNOWN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <u>266-48-4007</u>	
17. INFORMANT <u>Grace O'Phar</u> Address <u>CAMbridge Md.</u>			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Disease</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____					
21. I certify that I attended the deceased from <u>Dec 30</u> , 19 <u>58</u> , to <u>Feb 23</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Feb 23</u> , 19 <u>59</u> , and that death occurred at _____ M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>J. Edwin Fassett</u>		ADDRESS (Street, city or town, state) <u>227 Pine St-CAMbridge, Md.</u> DATE SIGNED <u>2-27-59</u>			
PHYSICIAN'S NAME (Type) <u>J. Edwin Fassett, M.D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAR. 1, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BAILEY TR.</u>	
22d. LOCATION (City, town, or county) <u>CAMbridge</u>		(State) <u>Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leon W. Henry</u>		ADDRESS <u>CAMbridge Md</u>		24a. REC'D BY REGISTRAR <u>APR 1 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

USE THE REV.

NO. 12-100-1  
XERO-CENT  
MAIN ROOM

Blank certificate form with horizontal lines for text entry.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1842

## CERTIFICATE OF DEATH

01844

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Cambridge</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Cambridge</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Lottie</u> Middle <u>Stanley</u> Last <u>Stanley</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>5</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 6, 1901</u>	9. AGE (In years last birthday) <u>57</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>5</u> Hours <u>5</u> Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Dorchester Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel Johns</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Jane Young</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Louise Wongus, RFD 2, Cambridge, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, lobular</u> 203X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General debility</u> DUE TO (c) <u>Multiple myeloma</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hepatitis C V.R.D.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Feb 4 '59</u> <u>May '58</u> <u>May '58</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 15, 1958</u> , to <u>Feb 5, 1959</u> , that I last saw the deceased alive on <u>May 15, 1958</u> , and that death occurred at <u>3 a. m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Cambridge, Md.</u> DATE SIGNED <u>Feb 9 '59</u>							
ACTUAL SIGNATURE <u>James H. Thompson</u> M.D.				PHYSICIAN'S NAME (Type) <u>James H. Thompson</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/9/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Salem Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Dorchester Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Williams Jr.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 13 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur H. Williams Jr.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be returned for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
1824 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01845

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>	c. LENGTH OF STAY IN 1b <b>entire life</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>13 Cambridge</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2 Cedar Street</b>		d. STREET ADDRESS <b>2 Cedar Street</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Elizabeth Simmons Thomas</b>		4. DATE OF DEATH Month Day Year <b>February 28, 1959 19</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 24, 1885</b>
9. AGE (In years last birthday) <b>73 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Taylors Island, Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>	
13. FATHER'S NAME <b>John Simmons</b>		14. MOTHER'S MAIDEN NAME <b>Anna (last name unknown)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-16-7309</b>	
17. INFORMANT <b>Henry S. Stephens, Cambridge, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic hypertensive cardio vascular renal disease.</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>?</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>---</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>---</b>	20f. (City or town) (County) (State) <b>---</b>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Eldridge H. Wolff</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Eldridge H. Wolff, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 2, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Kenneth R. Thomas</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 4 '59</b>	
ADDRESS <b>Cambridge, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G239 2-24-59 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

01846

1843

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Linkwood</b>				c. LENGTH OF STAY IN 1b <b>2 Month</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>"Mattie Murich Home"</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Thompson</b> Last <b>Thompson</b>				4. DATE OF DEATH Month <b>Feb</b> Day <b>14</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>About 87</b> yrs.		9. AGE (In years last birthday) <b>87</b> yrs.		10. IF UNDER 1 YEAR Months <b>14</b> Days <b>19</b> Hours <b>59</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School Teacher Ret.</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Teacher</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>
13. FATHER'S NAME <b>Samuel E. Thompson</b>				14. MOTHER'S MAIDEN NAME <b>Emily Webb</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Dr J U Thompson</b>		Address <b>Cambridge Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis - H. Thompson</b> <b>332x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio-sclerosis, gen</b> DUE TO (c) <b>?</b>							INTERVAL BETWEEN ONSET AND DEATH <b>14 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1952 to Feb 14, 1959</b> , that I last saw the deceased alive on <b>Feb 13, 1959</b> , and that death occurred at <b>2 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cambridge, Md</b> DATE SIGNED <b>Feb 16, 59</b>							
ACTUAL SIGNATURE <b>J. U. Thompson</b>		M.D. <b>Cambridge, Md</b>					
PHYSICIAN'S NAME (Type) <b>J. U. Thompson</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb 16, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Old Trinity</b>		22d. LOCATION (City, town, or county) (State) <b>Church Creek Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>LeCompte Funeral Service</b>				ADDRESS <b>Cambridge Maryland</b>		24a. REC'D BY REGISTRAR <b>FEB 19 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE	
JAMES H. HARRIS		65		M		W		1878		1943		HOME		BALTIMORE		BALTIMORE		MD	
FATHER		MOTHER		SPOUSE		CHILDREN		EDUCATION		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.		REGISTERED	
JAMES H. HARRIS		JANE H. HARRIS		MRS. JANE H. HARRIS		JAMES H. HARRIS		HIGH SCHOOL		LABORER		HEART DISEASE		NATURAL		12345		YES	
BROTHERS		SISTERS		GRANDCHILDREN		PARENTS		Siblings		Other		Other		Other		Other		Other	
JAMES H. HARRIS		JANE H. HARRIS		MRS. JANE H. HARRIS		JAMES H. HARRIS		HIGH SCHOOL		LABORER		HEART DISEASE		NATURAL		12345		YES	

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED  
DATE 10/15/2010 BY 60322 UCBAW/BJS/STP

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01847

1844

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Cambridge</b>				c. LENGTH OF STAY IN 1b <b>3 YEARS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address, OR INSTITUTION) <b>Eastern Shore State Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield 1939.2</b>			
				d. STREET ADDRESS <b>Second ST</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Annie L. Tilghman</b>				4. DATE OF DEATH Month Day Year <b>Feb 12 1959</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 2 1872</b>	9. AGE (In years last birthday) yrs. <b>86</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>WILLIAM H. WHARTON</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>Eastern Shore State Hospital records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocardial</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Degeneration</b> (c) <b>Unk</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Dec 8, 1956</b> , to <b>Feb 12, 1959</b> , that I last saw the deceased alive on <b>Feb 12, 1959</b> , and that death occurred at <b>110 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Thomas J. Dredge</b> M.D.				ADDRESS (Street, city or town, state) <b>E.S.S. Hospital, Cambridge, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Thomas J. Dredge</b>				DATE SIGNED <b>2-12-59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>FEB. 15, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>SUNNYRIDGE CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>CRISFIELD, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>BRADSHAW &amp; SONS - CRISFIELD, MD.</b>				42a. REC'D BY REGISTRAR <b>FEB 17 59</b>		24b. REGISTRAR'S SIGNATURE <b>Ed. E. K.</b>	





CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Federalsburg - Rural</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.F.D. #1</b>				e. STREET ADDRESS <b>R.F.D. #1</b>			
3. NAME OF DECEASED (Type or print) First <b>Isaac</b> Middle <b>Leonard</b> Last <b>Wheatley</b>				4. DATE OF DEATH Month <b>February</b> Day <b>1</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 13, 1886</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm Owner</b>		11. BIRTHPLACE (State or foreign country) <b>Dorchester Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Isaac L. Wheatley</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Davis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Lucy M. Wheatley, Federalsburg, Md., RFD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac - Collapsus.</b> <b>148X</b> DUE TO <b>Primary - Carcinoma Throat</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>General Metastasis -</b> DUE TO (c) <b>1956</b> <b>1957-2-1-59</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1-27-2-1-59</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>10-11-1956</b> to <b>31-1-59</b> , that I last saw the deceased alive on <b>27-1-59</b> , and that death occurred at <b>5:50 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W. E. Lennon</b> M.D.				ADDRESS (Street, city or town, state) <b>Federalsburg Md.</b> DATE SIGNED <b>2-2-59</b>			
PHYSICIAN'S NAME (Type) <b>W. E. Lennon, M.D.</b>				<b>Federalsburg, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 4, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hill Crest Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Federalsburg, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.J. Frampton and Son, Federalsburg, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 6 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

16  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

01849

1846

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>34.4 mo</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ERNEST ELIAH WHITE</u>		4. DATE OF DEATH <u>Feb. 28</u> 19 <u>59</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-16-82</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (State or foreign country) <u>Ind. (Parsonsborg)</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Turner White</u>	
14. MOTHER'S MAIDEN NAME <u>Emily Ennis</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>	
16. SOCIAL SECURITY NO. <u>Isabella St. Salisbury, Maryland</u>		17. INFORMANT <u>Mrs. Bertha E. White (Wife)</u> 508 E. <u>Isabella St. Salisbury, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>June 1957</u> to <u>Feb. 28, 1959</u> , that I last saw the deceased alive on <u>Feb. 27, 1959</u> , and that death occurred at <u>10:05</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. De Filippis</u> M.D.		ADDRESS (Street, city or town, state) <u>Eastern Shore State Hosp. Cambridge Md.</u> DATE SIGNED <u>2/28/59</u>	
PHYSICIAN'S NAME (Type) <u>E. DE FILIPPIS</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial March 3, 1959</u>		22b. DATE THEREOF _____	
22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery (Walston)</u>		22d. LOCATION (City, town, or county) <u>R.D. Salisbury, Md.</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u>		ADDRESS <u>SALISBURY MARYLAND</u>	
24a. REC'D BY REGISTRAR <u>MAR 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Howard</u>	

CERTIFICATE OF DEATH

1968



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1825

01850

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>13 Cambridge</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>408 Pine Street</u>				d. STREET ADDRESS <u>408 Pine Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>Emma</u> Last <u>Young</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>28</u> Year <u>19 59</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 28, 1908</u>	
9. AGE (In years lost birthday) <u>50 yrs.</u>		IF UNDER 1 YEAR Months <u>50</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Food Packing</u>		11. BIRTHPLACE (State or foreign country) <u>Dorchester County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Stephen Blake</u>				14. MOTHER'S MAIDEN NAME <u>Rosie Horsey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>220-10-6110</u>		17. INFORMANT <u>Henry Young, Cambridge, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>app 2 hrs</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>September 15, 1952</u> , to <u>February 28, 1959</u> , that I last saw the deceased alive on <u>February 28, 1959</u> , and that death occurred at <u>7 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>227 Pine St-Camb., Md.</u> DATE SIGNED <u>3-4-59</u>							
ACTUAL SIGNATURE <u>J. Edwin Fassett</u>				M.D. <u>J. Edwin Fassett, M.D.</u>			
PHYSICIAN'S NAME (Type) <u>J. Edwin Fassett, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/5/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kenna</u>				ADDRESS <u>Cambridge, Md.</u>		24a. REC'D BY REGISTRAR <u>9 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>							

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
JAMES C. SMITH		MALE		45		JAN 15 1880		NEW YORK		LABORER		MARRIED		WHITE	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH		13. DISEASE OR INJURY		14. PERIOD OF ILLNESS		15. PREVIOUS ILLNESS		16. SIGNATURE OF PHYSICIAN	
FEB 10 1900		10:30 AM		HIS HOME		HEART DISEASE		CORONARY ARTERY DISEASE		2 WEEKS		NONE		J. B. SMITH, M.D.	
17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF WITNESS		19. SIGNATURE OF DECEASED		20. SIGNATURE OF NEXT OF KIN		21. SIGNATURE OF CLERGYMAN		22. SIGNATURE OF BURIAL OFFICER		23. SIGNATURE OF FUNERAL HOME		24. SIGNATURE OF CEMETERY	
W. J. SMITH		J. B. SMITH		J. C. SMITH		J. D. SMITH		J. E. SMITH		J. F. SMITH		J. G. SMITH		J. H. SMITH	